Report of Accident (Workplace Injury, Accident or Occupational Disease)

Language preference (check one) ☒ English ☐ Español/Spanish ☐ русский/Russian ☐ Tiếng Việt/Vietnamese ☐ 繁體中文/Chinese Traditional ☐ 简体中文/Chinese Simplified ☐ 한국어/Korean ☐ ខ្មែរ/Cambodian ☐ Soomaali/Somali ☐ Other: Admit

Claim No. B [redacted]

Worker Information

1. Name (First-Middle-Last): Warren John Peterson
2. ☐ Male ☐ Female
3. Social Security Number: [redacted]
4. Home phone: [redacted]
5. Birth date: month / day / year
6. Home address: [redacted]
7. Height (ft-in.)
8. Weight
City: East Olympia State: WA ZIP Code: 98540
9. Mailing address (if different from home address)
City State ZIP Code
10. Family status: ☑ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐ Registered Domestic Partner

Family and dependent eligibility: *You may be required to show proof of marriage, domestic partnership registration, or dependent eligibility.*

Dependent Information

11. Dependent children include unborn/ estimate birth date. Benefits will be based in part on number of legally dependent children. If you don't have legal custody, complete Box 13.
12. Name of Spouse or Registered Domestic Partner: Lawni Peterson

Name	Relationship	Legal Custody	Birth date
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /

13. Name & address of children's legal guardian
Name Address
City State ZIP Code

Injury Information

14. Date of injury or last occupational exposure: 5/26/19
15. Time of injury: ____ ☐ AM ☐ PM
16. Shift (check one): ☐ Day ☐ Swing ☐ Night
17. Have you ever been treated for the same or similar condition? ☐ YES ☒ NO
18. Is this condition due to a specific incident? ☑ YES ☐ NO
19a. Body parts injured or exposed:
19b. Describe in detail how your injury or exposure occurred. (include tools, machinery, chemicals or fumes that may have been involved)
20. Were you doing your regular job? ☑ YES ☐ NO
21. Where did the injury or exposure occur? ☐ Employer Premises ☐ Jobsite ☐ Other:
22. Where did the injury/exposure occur? Name of business:
Address City County State ZIP
23. Injury caused by a faulty machine, product or person other than my employer or co-worker? ☐ YES ☐ NO ☐ POSSIBLY
24. List any witnesses:
25. When will you return to work? / /
26. When did you last work? 5/26/19
27. Did you report the incident to your employer? ☐ YES ☐ NO If "yes" write name and title:
28. Date you reported it: / /
29. Did you have employer-paid health care benefits on the day injured? ☐ YES ☐ NO

Employment Information

30. Business name of your employer: Thurston County Fire Dist. 6
31. Type of business
32. How long have you worked there? ____ Years ____ Months ____ Weeks ____ Days
33. Employer's phone: 360 491 6533
34. Your employer's address: P.O. Box 578
City: East Olympia State: WA ZIP Code: 98540
35. List your job title and describe your job duties
36. Rate of pay at this job (check one): $ ☐ Hour ☐ Week ☐ Day ☐ Month ☐ More than 1 rate of pay
37. Hours per day
38. Days per week
39. Additional earnings (daily average): $ (check all that apply) ☐ Piecework ☐ Regular overtime ☐ Commission ☐ Tips ☐ Shift diff. ☐ Bonuses in the last 12 months
40. How many paying jobs do you have?
41. I am a: ☐ Owner ☐ Partner ☐ Corp. Officer ☐ Corp. Shareholder ☐ Corp. Director ☐ Optional Coverage ☐ Does not apply to me

42. Signature **Note: READ LEGAL NOTICES ON THE WORKER'S COPY OF THIS FORM**
I declare these statements are true to the best of my knowledge and belief. In signing this form I permit health care providers, hospitals, or clinics to release relevant medical reports, which they or others produce, to the Dept. of Labor & Industries.
X Today's date / /

43. Signature
I authorize the Department of Labor & Industries, or others acting on their behalf, to obtain confidential employment records from the Employment Security Department (ESD) to help determine workers' compensation benefits.
X Today's date / /

Health Care Provider Information

1. Diagnosis	2. ICD Codes	1. Diagnosis	2. ICD Codes

3. Date you first saw patient for this condition: / /
Claim No. [redacted]
4. Is the condition due to a specific incident? ☐ YES ☐ NO
5. Objective findings supporting your diagnosis (include physical, lab and X-ray findings)
6a. Is more treatment needed? ☐ YES ☐ NO ☐ POSSIBLY
6b. Treatment and diagnostic testing recommendations:
7. Was the diagnosed condition caused by this injury or exposure? **Check one.** ☐ YES ☐ PROBABLY (51% or more) ☐ NO ☐ POSSIBLY (Less than 50%)
8. Will the condition cause the patient to miss work? ☐ YES ☐ NO If yes, estimate the number of days: ____
9. Is there any pre-existing impairment of the injured area? ☐ YES ☐ NO If YES, describe briefly or attach report.
10. Has patient ever been treated for the same or similar condition? ☐ YES ☐ NO If YES, provider name, city & year: Name City Year
11. Are there any conditions that will prevent or slow recovery? If YES, describe briefly or attach report. ☐ YES ☐ NO
12. Did you refer the patient to an L&I medical network provider for follow-up? Referred to: ☐ YES ☐ NO
13. Name of attending health care provider (Please print)
Patient's ID number, if available: [redacted]
14. **IMPORTANT: L&I Provider Number or NPI of provider listed in Box 13.**
15a. Name of hospital or clinic where patient was treated:
Name HMC
Address 325 9th Ave Seattle WA 98104
Phone 206 744-4074
15b. This exam date / /
16. Signature (NOTE: Licensed health care provider must sign report.)
X Today's date / /

F242-130-000 Report Of Accident (Workplace Injury, Accident or Occupational Disease) 10-15 **L&I'S COPY**